# House of Representatives

General Assembly

**File No. 355**

*February Session, 2014*

Substitute House Bill No. 5500

*House of Representatives, April 3, 2014*

The Committee on Human Services reported through REP. ABERCROMBIE of the 83rd Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

## *AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.*

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (d) of section 17b-99 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2014*):

(d) The Commissioner of Social Services, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider that participates as provider of services in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall conduct any such audit in accordance with the provisions of this subsection. For purposes of this subsection <u>"extrapolation" means the determination of an unknown value by projecting the results of the review of a sample of the universe from which the sample was drawn;</u>

"medical necessity" has the same meaning as provided in section 17b-259b; "provider" means a person, public agency, private agency or proprietary agency that is licensed, certified or otherwise approved by the commissioner to supply services authorized by the programs set forth in said chapters; and "universe" means a defined population of claims submitted by a provider during a specific time period.

(1) The Commissioner of Social Services, or any entity with which the commissioner contracts for the purpose of conducting an audit of a service provider pursuant to this subsection, shall have access during a provider audit only to information relevant to the audit, including, but not limited to, information concerning: (A) Services and goods provided and billed to the Medicaid program during the time period covered by the audit, (B) medical necessity of such services and goods provided, and (C) whether the provider billed responsible third parties for such services or goods provided. Nothing in this subsection shall be construed as authorizing access to any information that is confidential or prohibited from disclosure by law. Not less than thirty days prior to the commencement of any such audit, the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider, shall provide written notification of the audit to such provider, unless the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider makes a good faith determination that **[**(A)**]** the health or safety of a recipient of services is at risk**[**;**]** or **[**(B)**]** the provider is engaging in vendor fraud. A copy of the regulations established pursuant to subdivision (11) of this subsection shall be appended to such notification.

(2) Any clerical error, including, but not limited to, recordkeeping, typographical, scrivener's or computer error, discovered in a record or document produced for any such audit shall not of itself constitute a wilful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established. In determining which providers shall be subject to audits, the Commissioner of Social Services shall first select providers with a higher compliance risk based

on past audits or errors. To the extent reasonably feasible, the commissioner, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, shall limit extrapolation of underpayments or overpayments based on a clerical error to similar claims, including, but not limited to, claims billed under the same medical billing codes.

(3) A finding of overpayment or underpayment to a provider in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a provider for which rates are established pursuant to section 17b-340, shall not be based on extrapolated projections unless (A) there is a sustained or high level of payment error involving the provider, or (B) documented educational intervention has failed to correct the level of payment error. **[**, or (C) the value of the claims in aggregate exceeds one hundred fifty thousand dollars on an annual basis.**]**

(4) A provider, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such provider in the course of any such audit.

(5) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall produce a preliminary written report concerning any audit conducted pursuant to this subsection, and such preliminary report shall be provided to the provider that was the subject of the audit not later than sixty days after the conclusion of such audit.

(6) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service

provider for which rates are established pursuant to section 17b-340, shall, following the issuance of the preliminary report pursuant to subdivision (5) of this subsection, hold an exit conference with any provider that was the subject of any audit pursuant to this subsection for the purpose of discussing the preliminary report. Such provider may present evidence at such exit conference refuting findings in the preliminary report.

(7) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider, shall produce a final written report concerning any audit conducted pursuant to this subsection. Such final written report shall be provided to the provider that was the subject of the audit not later than sixty days after the date of the exit conference conducted pursuant to subdivision (6) of this subsection, unless the commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider, agrees to a later date or there are other referrals or investigations pending concerning the provider.

(8) Any provider aggrieved by a decision contained in a final written report issued pursuant to subdivision (7) of this subsection may, not later than thirty days after the receipt of the final report, request, in writing, a review on all items of aggrievement. Such request shall contain a detailed written description of each specific item of aggrievement. The designee of the commissioner who presides over the review shall be impartial and shall not be an employee of the Department of Social Services Office of Quality Assurance or an employee of an entity with which the commissioner contracts for the purpose of conducting an audit of a service provider. Following review on all items of aggrievement, the designee of the commissioner who presides over the review shall issue a final decision.

(9) A provider may appeal a final decision issued pursuant to subdivision (8) of this subsection to the Superior Court in accordance with the provisions of chapter 54.

(10) The provisions of this subsection shall not apply to any audit conducted by the Medicaid Fraud Control Unit established within the Office of the Chief State's Attorney.

(11) The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, to carry out the provisions of this subsection and to ensure the fairness of the audit process, including, but not limited to, the sampling methodologies associated with the process. The commissioner shall provide free training to providers on how to enter claims to avoid clerical errors and shall post information on the department's Internet web site concerning the auditing process and methods to avoid clerical errors. Not later than October 1, 2014, the commissioner shall (A) convene a meeting with representatives of the dental profession concerning billing, record-keeping procedures and standards of such profession and any modifications in the auditing process concerning dental providers that may be necessary and federally permissible, and (B) ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, has on staff or consults with a medical or dental professional who is experienced in the treatment, billing and coding procedures used by the provider subject to audit during such audit.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *July 1, 2014* | 17b-99(d) |

***HS*** *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

## *OFA Fiscal Note*

### *State Impact:*

| Agency Affected | Fund-Effect | FY 15 $ | FY 16 $ |
|---|---|---|---|
| Resources of the General Fund | GF - Revenue Loss | Significant | Significant |
| Department of Social Services | GF - Cost | Significant | Significant |

***Municipal Impact:*** None

### *Explanation*

The bill changes the methods by which the Department of Social Services (DSS) audits providers under the Medicaid program. These changes include limiting the information that DSS may access related to an audit and limiting the use of extrapolation to claims billed under the same medical billing code. These limitations are likely to significantly reduce the department's ability to recoup overpayments.

Over the past four years, DSS has averaged $27 million annually in recoupments and cost avoidance due to its current auditing processes. Of the audits completed over the first eight months of FY 14, only 6% of recoupments were based on the extrapolation of similar billing codes. Under current practice, this would represent only $1.6 million in recoupments annually based on extrapolating similar billing codes.

While it cannot be known in advance to what extent the requirement to extrapolate only on similar billing codes will reduce the auditing results, based on the current years information, it will likely be significant. For purposes of illustration, each 25% reduction in audit results would cost $6,750,000 annually. Depending upon the type of audit, recoupments are either returned to the department to

offset expenditures or booked to the General Fund as revenue.

The bill further requires DSS to provide training on how to enter claims to avoid clerical errors. DSS already provides this information during provider enrollment and update bulletins. There is no anticipated further fiscal impact.

### *The Out Years*

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

**OLR Bill Analysis**

**sHB 5500**

***AN ACT CONCERNING PROVIDER AUDITS UNDER THE MEDICAID PROGRAM.***

**SUMMARY:**

This bill makes several changes in the Department of Social Services' (DSS) Medicaid provider audit process. Specifically, it:

1. limits the information the DSS commissioner or a DSS-contracted auditor may access during an audit of service providers;

2. limits the types of claims the commissioner and auditors may use to extrapolate the incidence of overpayments or underpayments based on clerical errors (i.e., determine an unknown value by projecting the results of a sample of claims a provider submitted during a specific time);

3. in determining which providers to audit, requires the DSS commissioner to select those with a higher compliance risk based on past audits;

4. eliminates a requirement that claims on which extrapolation is used have an aggregate value of at least $150,000 on an annual basis; and

5. allows an audited provider to present evidence to the commissioner or an auditor to refute the audit's findings.

The bill also requires DSS to (1) provide free provider training on how to enter claims to avoid clerical error and (2) post information on the DSS website about the auditing process and ways to avoid clerical errors.

By October 1, 2014, the bill also requires the DSS commissioner to (1) meet with dental profession representatives about billing, record-keeping procedures, dental profession standards, and any audit process modifications concerning dental providers that may be necessary and federally permissible and (2) ensure that DSS or any DSS-contracted auditor, during an audit, has on staff or consults with a medical or dental professional experienced in the treatment, billing, and coding procedures of the provider being audited.

EFFECTIVE DATE: July 1, 2014

## DSS SERVICE PROVIDER AUDITS

### *Limits on Information Access*

The bill limits the information the DSS commissioner or any entity with whom he contracts to conduct a service provider audit can access during an audit to information relevant to the audit. Such information includes (1) services and goods the provider provided and billed to Medicaid during the period the audit covers, (2) the medical necessity (see BACKGROUND) of the services and goods, and (3) whether the provider billed responsible third parties for them. It does not include information that is confidential or illegal to disclose.

### *Provider Audit Prioritization and Claim Extrapolation*

The bill requires the DSS commissioner to prioritize which service providers to audit. It does so by requiring him to first select providers with a higher compliance risk based on past audits or errors. It also limits, to the extent reasonably feasible, the commissioner's and any DSS-contracted auditor's use of extrapolation of underpayments or overpayments based on a clerical error to similar claims, including those billed under the same medical billing code.

The bill also broadens the circumstances in which DSS or a DSS-contracted auditor may base a finding of provider overpayment or underpayment on extrapolated projections. Under current law, such findings cannot be based on extrapolated projections unless (1) there is a sustained or high level of payment error involving the provider, (2)

the provider has failed to correct the level of payment error despite documented educational intervention, and (3) the claims' aggregate value exceeds $150,000 on an annual basis. The bill eliminates the $150,000 aggregate value minimum, thereby allowing extrapolation for any amount.

### *Evidence to Refute Audit Findings*

By law, the DSS commissioner or any DSS-contracted auditor, after issuing a preliminary report, must hold an exit conference with an audited provider to discuss the report. The bill allows the audited provider to present evidence at the exit conference that refutes the report's findings.

## BACKGROUND

### *Medical Necessity*

"Medical necessity" means those health services required to prevent, identify, diagnose, treat, rehabilitate, or ameliorate a person's medical condition, including mental illness, or its effects, in order to attain or maintain the person's achievable health and independent functioning. The services must be consistent with generally accepted medical practice standards based on (1) credible scientific evidence published in recognized peer-reviewed medical literature, (2) physician-specialty society recommendations, (3) the views of physicians practicing in relevant clinical areas, and (4) any other relevant factors.

The services must also be:

1. clinically appropriate in terms of type, frequency, timing, extent, and duration and considered effective for the person's illness, injury, or disease;

2. not primarily for the convenience of the person, the person's health care provider, or other health care providers;

3. not more costly than alternative services at least as likely to produce equivalent therapeutic or diagnostic results for the

person's illness, injury, or disease; and

4. based on an assessment of the person and his or her medical condition (CGS § 17b-259b).

## COMMITTEE ACTION

Human Services Committee

Joint Favorable Substitute
Yea 17 Nay 0 (03/20/2014)